No. 05-380

FILED
MAY 2 2 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., and JILL L. VIBHAKAR, M.D., on behalf of themselves and their patients,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF JOHN M. THORP, JR., M.D., and MATERCARE INTERNATIONAL AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

JAMES L. HIRSEN
Adjunct Professor of Law
TRINITY LAW SCHOOL
505 S. Villa Real Dr., Ste. 208
Anaheim Hills, CA 92807
Telephone: (714) 283-8880

NIKOLAS T. NIKAS
DORINDA C. BORDLEE
Counsel of Record
BIOETHICS DEFENSE FUND
6811 E. Voltaire Ave.
Scottsdale, AZ 85254
Telephone: (480) 483-3597

Counsel for Amici Curiae

May 22, 2006

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF THE *AMICI CURIAE*	1
SUMMARY OF THE ARGUMENT	2
ARGUMENT	5
I. THE LOWER COURTS ERRED IN BLINDLY APPLYING A "HEALTH EXCEPTION" REQUIREMENT TO A STATUTE THAT BANS A PROCEDURE THAT IS IN AND OF ITSELF DANGEROUS TO WOMEN'S HEALTH	5
A. Partial-Birth Abortion Poses Serious Medical Risks to the Health of Women	7
i. Long-Term Risk of Cervical Incompetence and Preterm Birth	7
ii. Risks Associated with Version to Footling Breech Position	11
iii. Risks Associated with Scissors	12
B. Abortion in General, including Partial Birth Abortion, Poses Other Serious Long-Term Health Risks	13
i. Placenta Previa	13
ii. Suicide and Self-Harm	14
iii. Breast Cancer Due to Loss of Protective Effect of First Full Term Pregnancy	15
CONCLUSION	17

TABLE OF AUTHORITIES

Page

CASES

Ayotte v. Planned Parenthood, 126 S. Ct. 961 (2006) 5, 6

Doe v. Bolton, 410 U.S. 179 (1973) 5, 7

Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983) 6

Planned Parenthood v. Casey, 505 U.S. 833 (1992) 5

Planned Parenthood v. Danforth, 428 U.S. 52 (1976) 6

Roe v. Wade, 410 U.S. 113 (1973) 5, 6, 7

Stenberg v. Carhart, 530 U.S. 914 (2000) 3, 5

Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986) 6

STATUTES

Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) 2, 4, 6, 8

MISCELLANEOUS

A. Gilchrist et al., *Termination of Pregnancy and Psychiatric Morbidity*, BR. J. PSYCHIATRY, 167, 1995, at 243-248 15

Amy R. Sobie & David C. Reardon, *Detrimental Effects of Adolescent Abortion*, THE POST ABORTION REVIEW Vol. 9(1), Jan.-Mar. 2001, *at* http://www.afterabortion.info/PAR/V9/n1/teens_vs_older.htm (last visited Jul. 29, 2005) 15

TABLE OF AUTHORITIES – Continued

Page

Brent Rooney and Byron C. Calhoun, M.D., *Induced Abortion and Risk of Later Premature Births*, 8 J. AM. PHYSICIANS & SURGEONS 46, 47 (Summer 2003) 11

C. Ananth et al., *The Association of Placenta Previa with History of Cesarean Section and Abortion: A Meta-Analysis*, AM. J. OBSTET. GYNECOL., 177, 1997, at 1071-1078 13

C. Morgan et al., *Suicides after Pregnancy*, (letter) BMJ, 314, 1997 15

D.C. Reardon et al., *Deaths Associated with Pregnancy Outcome: A Linkage-Based Study of Low Income Women*, SOUTH. MED J., 2002, 95:834-841 14

Gissler, *Suicides after Pregnancy in Finland, 1987-94: Register Linkage Study*, BMJ, 1996, 313:1431-1434 14

J.M. Thorp, Jr., M.D., K.E. Hartmann, M.D., Ph.D., and E.M. Shadigian, M.D., *Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence*, OB/GYN SURVEY, 58(1), 2003, at 67-79 ..... *passim*

Joachim A. Martius et al., *Risk Factors Associated with Preterm (<37 + 0 weeks) and Early Preterm Birth (<32+ 0 weeks): Univariate and Multivariate Analysis of 106,345 Singleton Births from the 1994 Statewide Perinatal Survey of Bavaria*, EUROPEAN JOURNAL OF OBSTETRICS AND GYNECOLOGY AND REPRODUCTIVE BIOLOGY, 80, 1998, at 183-189 9

M. McMahon et al., *Age at First Birth and Breast Cancer Risk*, BULL. WORLD HEALTH ORGAN., 43, 1970, at 209-221 15

TABLE OF AUTHORITIES – Continued

Page

March of Dimes, *Complications of Premature Birth*, at http://www.marchofdimes.com/prematurity/5512.asp (last visited May 18, 2006) 11

Reviewing the Medical Evidence: Long-Term Physical and Psychological Health Consequences of Induced Abortion, U.S. Senate Subcomm. on Sci., Tech. and Space, Statement of Elizabeth M. Shadigian, M.D. (March 3, 2004) 10, 13, 14, 15

W. Chie et al., *Age at Any Full-Term Pregnancy and Breast Cancer Risk*, 151 Am J. Epidemiology 715 (2000) 15

INTEREST OF THE *AMICI CURIAE*[1]

John M. Thorp, Jr., M.D. is the McAllister Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina, Chapel Hill School of Medicine. He has an active practice in obstetrics and gynecology with over 4000 patients. Dr. Thorp serves as Co-Director of the North Carolina Program for Women's Health Research. In that capacity, he has conducted comprehensive research on various topics including perinatal substance abuse, preterm birth, and the health effects of induced abortion on women's health. He served as lead author of the peer-reviewed study that forms the basis of this brief: J.M. Thorp, Jr., M.D., K.E. Hartmann, M.D., Ph.D., and E.M. Shadigian, M.D., *Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence,* OB/GYN SURVEY 58(1): 67-79, 2003.

Dr. Thorp has an extensive research history including key roles in more than 45 major funded studies, including a prospective cohort of pregnancy outcomes that is in its third cycle of federal funding. Dr. Thorp is a productive author with more than 100 peer-reviewed publications, 20 commentaries, and 12 book chapters to his credit. Of note, he is an experienced editor and peer reviewer, who reviews for journals ranging from the *New England Journal of Medicine* to *Pediatric and Perinatal Epidemiology*, with a special interest in advancing the quality of the literature

---

[1] Pursuant to Sup. Ct. R. 37.6, *amici* state that none of the counsel for the parties authored this brief in whole or in part. Monetary funding for the preparation of this brief has been requested in part from the Alliance Defense Fund. Pursuant to Sup. Ct. R. 37.3(a), the parties have consented to the filing of this brief. Letters of consent are being filed with the Clerk.

in women's health. He was recently honored by the editors of *Obstetrics and Gynecology* as among their most valued reviewers.

Matercare International is a nonprofit international organization of Catholic health professionals (obstetricians, neonatologists, general practitioners, midwives and others) whose mission is to address and provide practical solutions to the poor state of maternal health throughout the world as indicated by the unacceptably high maternal mortality, morbidity and abortion rates. Health Care professionals in the United States are an important part of Matercare International. In addition to collaborating with other health organizations to provide maternal health care in Ghana, Kenya and Rwanda, Matercare International members engage in research of the highest scientific and ethical standards to assist in the care of mothers both pre-natal and post-natal.

In the interest of protecting the health of women considering late-term abortion, *amici curiae,* John M. Thorp, Jr., M.D. and Matercare International, seek to inform this Court of the serious long-term and immediate health risks associated with partial-birth abortion in particular, as well as abortion in general.

SUMMARY OF THE ARGUMENT

The Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) ("the Act") is a constitutionally valid prohibition of a procedure[2] that Congress

[2] While Congress used the term partial birth "abortion" to describe the procedure being banned, there is a solid argument that the term abortion is a misnomer. Indeed, since the destruction of the partially

(Continued on following page)

appropriately determined to be not only unnecessary, but also **dangerous** to the health of women. *Amici* Professor John M. Thorp, M.D. and Matercare International present this Court with compelling evidence in support of Congress's

---

born child occurs while most of the child is in the birth canal, the relevant medical science and this Court's abortion jurisprudence stating that women have a "right to choose to terminate their *pregnancy*" (pregnancy being medically defined as occurring in the uterus) strongly support the conclusion that what is being banned is more accurately described as "partial birth *infanticide*." This Court has never held that a ban on infanticide must include a health exception. (For a complete medical and legal analysis of why partial birth "abortion" is infanticide at its earliest point, *see Brief of Amici Curiae Louisiana and Mississippi in Support of Petitioners* in *Stenberg v. Carhart*, 530 U.S. 914 (2000)). Indeed, as Justice Thurgood Marshall commented during the second oral argument in *Roe*, killing a child in the process of birth "is not an abortion":

> **JUSTICE MARSHALL:** What does that [parturition] statute mean?
>
> **MR. FLOWERS:** Sir?
>
> **JUSTICE MARSHALL:** What does it mean?
>
> **MR. FLOWERS:** I would think that –
>
> **JUSTICE STEWART:** That it is an offense to kill a child in the process of childbirth?
>
> **MR. FLOWERS:** Yes sir. It would be immediately before childbirth, or right in the proximity of the child being born.
>
> **JUSTICE MARSHALL:** *Which is not an abortion.*
>
> **MR. FLOWERS:** Which is not – would not be an abortion, yes, sir. You're correct, sir. It would be homicide.
>
> Reargument of *Roe v. Wade*, October 11, 1972 (emphasis added).

This exchange between Justice Marshall and counsel for the State of Texas occurred during the 1972 reargument of *Roe* in the context of a discussion about the Texas parturition statute, which had not been challenged as unconstitutional.

The entire written transcript of the October 11, 1972 reargument can be found at http://www.oyez.org/oyez/resource/case/334/reargument/transcript (last checked May 18, 2006).

informed determination that, beyond being "unnecessary," partial birth abortion "poses serious risks to the long-term health of women, and in some circumstances, their lives."[3]

A health exception to a procedure that is itself a health risk simply would not make sense. Indeed, the Act logically requires no health exception to survive constitutional scrutiny because an overt act that itself endangers a woman's health cannot be deemed to be medically necessary.

Amici confirm the validity of the medical testimony that formed the basis of Congress's determination that partial-birth abortion poses serious long-term and short-term increased medical risks including:

1. Long-Term Risk of Cervical Incompetence and Preterm Birth;

2. Risks Associated with Version to Footling Breech Position; and

3. Risks Associated with Scissors

In addition, *Amici* present this Honorable Court with a summary of long-term health risks associated with abortion in general as presented in a 2003 peer-reviewed systematic review article whose lead author is *amicus curiae* Professor John M. Thorp, M.D.[4] The review article

---

[3] Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2(2), 117 Stat. 1201 (2003) ("Act").

[4] J.M. Thorp, Jr., M.D., K.E. Hartmann, M.D., Ph.D., and E.M. Shadigian, M.D., *Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence*, OB/GYN SURVEY, 58(1), 2003, at 67-79 ("the OGS Review").

The OGS Review was entered into evidence in the district court as Defendant's Exhibit #631. Tr. 1548:7. Dr. Elizabeth Shadigian,

(Continued on following page)

analyzed the medical literature of the first 30 years of legalized abortion, and found that, in addition to the increased risk of cervical incompetence and preterm birth particularly associated with partial-birth abortion, induced abortion in general is associated with increased long-term risks of:

1. Placenta Previa;

2. Suicide and Self-Harm; and

3. Breast cancer due to loss of protective effect of first full-term pregnancy.

ARGUMENT

I. THE LOWER COURTS ERRED IN BLINDLY APPLYING A "HEALTH EXCEPTION" REQUIREMENT TO A STATUTE THAT BANS A PROCEDURE THAT IS IN AND OF ITSELF DANGEROUS TO WOMEN'S HEALTH

While concern for women's health has been a constant theme in this Court's jurisprudence addressing abortion regulations,[5] an authentic concern for women's health must also consider the risks and dangers of abortion itself on women's health as documented in respected medical journals.

---

co-author of the OGS Review, testified about the study at pages 1534-1543 of the trial transcript. Tr. 1534-1543.

[5] *Roe v. Wade*, 410 U.S. 113, 164-65 (1973); *Doe v. Bolton*, 410 U.S. 179, 192 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992); *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000); *Ayotte v. Planned Parenthood*, 126 S. Ct. 961, 967 (2006).

The lower courts failed to give enough weight to the evidence supporting Congress's informed determination that partial-birth abortion is a procedure that "poses serious risks to a woman's health [which] lies outside the standard of medical care."[6] The lower courts further erred when they, as if by rote, ruled that a **health exception** is constitutionally required for an Act that bans a procedure that itself is a **health threat** to women.

Amici submit that the Act logically requires no health exception to survive constitutional scrutiny because an overt act that itself endangers a woman's health cannot be deemed to be "necessary, in appropriate medical judgment, for preservation of the life or health of the mother," as required by this Court's jurisprudence. *Ayotte v. Planned Parenthood*, 126 S. Ct. 961, 967 (2006).[7]

While some *amici* supporting Petitioner address the medical evidence supporting Congress's finding that partial-birth abortion is never **necessary** to preserve the health of the mother,[8] *Amici* Dr. John M. Thorp and Matercare International present this Court with compelling evidence supporting Congress's important and determinative findings concerning the **dangers** posed by "the serious risks to the long-term health of women"[9] associated

---

[6] Act, *supra* note 3, at §13.

[7] *Id.* (quoting *Roe*, 410 U.S. at 164-165); also citing *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-769 (1986); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 482-486 (1983) (opinion of Powell, J.); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 79 (1976).

[8] *See Brief Amici Curiae of the American Association of Pro-Life Obstetricians and Gynecologists, et al.*

[9] Act, *supra* note 3, at §2(2).

with partial-birth abortion, as well as its short-term risks of immediate complications.

A. Partial-Birth Abortion Poses Serious Medical Risks to the Health of Women

To assist this Court's analysis of whether a health exception[10] is required to uphold the constitutionality of the Act, *Amici* bring this Court's attention to the evidence, as presented in the record of both Congress and in the district court, of the three serious health risks posed specifically by the partial-birth abortion procedure: 1) **cervical incompetence and preterm birth**, 2) **uterine trauma** caused as a result of converting the child to a footling breech position, and 3) **risk of severe bleeding** caused by using scissors to pierce the fetus's head while it is inside the woman's cervix.

i. Long-Term Risk of Cervical Incompetence and Preterm Birth

Partial-birth abortion, as described by those who use the procedure, requires more cervical dilation than that

---

[10] Because *Roe* allowed abortion in the second and third trimesters for the "life or health" of the mother, the following definition of "health" has been used by abortion providers to make abortion on demand available through all nine months of pregnancy:

> "[T]he medical judgment may be exercised in the light of all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well being of the patient. All these factors may relate to health." *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

Amici urge this Court to address this overbroad definition of "health."

required in other abortion procedures.[11] Congress found that partial-birth abortion poses an "increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term." Act, §2(14)(A).

This finding is supported by a multitude of studies included in a landmark 2003 peer-reviewed abstract of the body of abortion-related health studies over the first thirty years of legalized abortion entitled "*Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence*" ("the OGS Review") (*see* Appendix which contains an internet link to full article).[12] The OGS Review evaluated over sixty international studies that included more than one million women. The study's authors, lead by Dr. John M. Thorp, *amicus* herein, are dedicated to gold standard research and hail from prestigious university medical programs.[13]

---

[11] Congress considered the statement of Dr. Haskell's 1992 NAF paper that partial-birth abortion involves an amount of dilation beyond that of D&E. Dr. Haskell described this process as "Dilation and **MORE DILATION**" involving the use of up to 25 osmotic dilators on the second day alone. *June 17 Hearing* at 17 (emphasis of "MORE DILATION" in original).

[12] "*Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence,*" by J.M. Thorp, Jr., M.D., K.E. Hartmann, M.D., Ph.D., and E.M. Shadigian, M.D., OB/GYN SURVEY, 58(1), 2003, at 67-79.

The OGS Review was entered into evidence in the Nebraska District Court as Defendant's Exhibit #631. Dr. Elizabeth Shadigian, co-author of the OGS Review, testified about the study at pages 1534-1543 of the trial transcript.

[13] *John M. Thorp, Jr., M.D.* (*Amicus Curiae* herein), McAllister Distinguished Professor of Obstetrics and Gynecology, Department of Epidemiology, School of Public Health, and Department of Obstetrics

(Continued on following page)

Of the several increased health risks surveyed in the OGS Review, of most relevance to the partial-birth abortion procedure is the study's conclusions concerning preterm birth. Dr. Elizabeth Shadigian, a co-author of the OGS Review, testified at trial that preterm birth is a potential long-term risk of partial-birth abortion (also referred to as D&X) because "we are talking [about] a much greater size of the baby, and this baby being pulled through a partially-open cervix such that . . . the potential for damage to the cervix is much greater in a D&X procedure than it would be in a simple first trimester procedure."[14]

The OGS Review explains that preterm birth is a major cause of "perinatal [infant] mortality and neurological long-term morbidity" in industrialized nations.[15] The OGS Review found twenty-four studies that explored the connections between induced abortion and preterm birth

---

and Gynecology, School of Medicine, University of North Carolina, Chapel Hill; Co-Director of the North Carolina Program for Women's Health Research.

Katherine E. Hartmann, M.D., Ph.D., Assistant Professor, Department of Epidemiology, School of Public Health, and Department of Obstetrics and Gynecology, School of Medicine, University of North Carolina, Chapel Hill; Director of the North Carolina Program for Women's Health Research.

Elizabeth Shadigian, M.D., Clinical Associate Professor, Department of Obstetrics and Gynecology, School of Medicine, University of Michigan, Ann Arbor.

[14] Tr. 1549-1550 (Elizabeth Shadigian, M.D.).

[15] OGS Review, *supra* note 12 at 70, n. 70 (citing Joachim A. Martius et al., *Risk factors associated with preterm (<37 + 0 weeks) and early preterm birth (<32+ 0 weeks): univariate and multivariate analysis of 106, 345 singleton births from the 1994 statewide perinatal survey of Bavaria*, EUROPEAN JOURNAL OF OBSTETRICS AND GYNECOLOGY AND REPRODUCTIVE BIOLOGY, 80, 1998, at 183-189.)

or low birth weight.[16] "Twelve studies found an association which almost **doubled** the risk of preterm birth. Moreover, seven of the twelve identified a higher risk for preterm birth for women who have had more abortions."[17]

Congress considered what *Amici* deem to be accurate medical testimony that the increased amount of dilation required in partial-birth abortion increases the risk of premature delivery in a subsequent pregnancy. *See, e.g., Nov. 1995 Hearing* at 77 (statement of Dr. Pamela Smith) ("[b]ecause you are forcefully dilating [the cervix] and opening it over a course of three days, [a woman] . . . could develop a problem called incompetent cervix," and she "will not be able to deliver a baby or carry a baby to term"); *March 2003 Hearing* at 114 (statement of Dr. Camilla C. Hersh) ("[a] woman's cervix is forcibly dilated over several days. This risks creating an incompetent cervix, a leading cause of subsequent premature delivery"); and *March 1997 Hearing* at 122 (statement of Dr. Curtis Cook) (partial birth abortion "involves several techniques which are concerning. . . , the first of which is the forceful placement of multiple dilators into the cervix, leading to potential cervical complications").

A pregnancy resulting in pre-term birth for a woman who had undergone a previous partial-birth abortion can result in tragic medical conditions for her subsequently born infant. The elevated risk of pre-term birth can result in newborns suffering from a variety of health problems

---

[16] OGS Review, *supra* note 12, at 70; *see also, Reviewing the Medical Evidence: Long-Term Physical and Psychological Health Consequences of Induced Abortion*, U.S. Senate Subcomm. on Sci., Tech. and Space, Statement of Elizabeth M. Shadigian, M.D. (March 3, 2004) ("Shadigian Senate Testimony.").

[17] OGS Review, *supra* note 12, at 70.

and disabilities including, among other things, cerebral palsy,[18] incomplete lung development, and sight or hearing problems for the infant due to underdeveloped eyes and ears. The March of Dimes summarizes nine complications associated with preterm birth: (1) Respiratory Distress Syndrome; (2) Intraventricular Hemorrhage; (3) Necrotizing Enterocolitis; (4) Retinopathy of Prematurity; (5) Chronic Lung Disease; (6) Infections; (7) Anemia; (8) Patent Ductus Arteriosus; and (9) Apnea.[19]

ii. Risks Associated with Version to Footling Breech Position

In addition to the long-term risk of cervical incompetence and preterm birth, Congress properly considered the short-term risks of immediate complications.

Congress considered evidence that partial-birth abortion involves the "routine version" of a fetus "into a breech (feet first) position, followed by extraction of the fetus up to the neck, when the base of the fetal skull is perforated with surgical instruments." *Nov. 1995 Hearing* at 246 (statement of Dr. Warren Hern).

Congress considered reliable evidence that "internal rotation, or version [of the unborn child] is a technique largely abandoned in modern obstetrics"[20] and that it is a

---

[18] Brent Rooney and Byron C. Calhoun, M.D., *Induced Abortion and Risk of Later Premature Births*, 8 J. AM. PHYSICIANS & SURGEONS 46, 47 (Summer 2003).

[19] March of Dimes, *Complications of Premature Birth*, at http://www.marchofdimes.com/prematurity/5512.asp (last visited May 18, 2006). *Id.*

[20] *March 1997 Hearing* at 123 (statement of Dr. Curtis Cook).

"rarely used [technique] . . . because it has high risks to both mother and baby, and the risk to the mother is primarily **rupture of the uterus**."[21]

Risk of uterine rupture or trauma such as a tearing in the lateral wall of the uterus is an obvious risk of partial-birth abortion considering that internal conversion of the fetus in the uterus is performed by literally flipping the fetus around.[22] This risky practice is done solely for the purpose of getting the fetus who is normally in a head down position turned around into a feet-first breech position so that when the child's body is brought into the vaginal canal, the head can be held inside of the cervix and the skull can be emptied and crushed before delivery is fully completed.

iii. Risks Associated with the Scissors

Congress also heard evidence that using scissors to pierce the base of fetus's skull while it is inside the woman's cervix presents risks of maternal injury.[23] Dr. Mark G. Neerhof explained in his statement to Congress that blindly forcing scissors into the base of the fetus's head "risks maternal injury from laceration of the uterus or cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death."[24]

---

[21] *Nov. 1995 Hearing* at 140 (testimony of Dr. Pamela Smith) (emphasis added).

[22] *Id.*

[23] *March 2003 Hearing* at 115 (letter from Dr. Hersh).

[24] *Id.* at 7 (statement of Dr. Neerhof).

B. Abortion in General, including Partial-Birth Abortion, Poses Other Serious Long-Term Health Risks

The thirty year survey of the long-term impact of abortion on women's health in the OGS Review concluded that induced abortion in general (which would include partial-birth abortion) is associated with increased risks of placenta previa, serious mental health disorders/suicide, and breast cancer due to loss of protective effect of first full-term pregnancy.

i. Placenta Previa

The medical condition where the placenta covers the cervix, making a cesarean section necessary to deliver the baby, is called "placenta previa."

When pregnancies are complicated by placenta previa, the result is high rates of preterm birth, low birth weight babies, and infant death.[25] Women who develop this condition are also at an increased risk for blood loss, subsequent blood transfusions, and hysterectomies (loss of the uterus) which thus require more extensive surgery.[26]

All of the three studies that have been done with over 100 subjects and one meta-analysis found a positive association between induced abortion and placenta previa. The OGS Review concluded that induced abortion increases the

---

[25] OGS Review, *supra* note 12, at 70, n. 27 (citing C. Ananth et al., *The association of placenta previa with history of cesarean section and abortion: A meta-analysis*, AM. J. OBSTET. GYNECOL., 177, 1997, at 1071-1078.)

[26] Shadigian Senate Testimony, *supra* note 16; OGS Review, *supra* note 12, at 70.

risk of placenta previa in subsequent pregnancy by approximately 50%.[27]

ii. Suicide and Self-Harm

One of the most dramatic and disturbing tabulations of the OGS Review is the increased risk of death by suicide. In addition to a variety of mental health disorders including depression, two studies, one from the United States and the other from Finland, have shown startling increased rates of suicide following abortion.[28] This phenomena is not seen after miscarriage.[29]

The United States study showed that women who had abortions were **2.5 times** more likely to die from suicide.[30] The Finland study showed that women who had abortions were **3.1 times** more likely to die from suicide than non-pregnant women and **6.5 times** more likely to die from suicide than women who completed their pregnancy.[31]

The Finland study further showed that teenagers who have abortions are **two to four times** more likely to

---

[27] OGS Review, *supra* note 12, at 70, 75 (cited in Shadigian Senate Testimony, *supra* note 16).

[28] *Id.* at 74. *See also,* Shadigian Senate Testimony, *supra* note 16.

[29] OGS Review, *supra* note 12, at 74 (miscarriage referred to medically as "spontaneous abortion").

[30] *Id.* at 73, n. 96 (Table 7, ref. n. 96, citing David C. Reardon et al., *Deaths Associated With Pregnancy Outcome: A Linkage-based Study of Low Income Women*, SOUTH. MED J., 2002, 95:834-841.)

[31] *Id.* at 73, n. 90 (Table 7, ref. n. 90, citing Gissler, *Suicides after pregnancy in Finland, 1987-94: Register linkage study,* BMJ, 1996, 313:1431-1434).

commit suicide compared to women who have abortions in adulthood.[32]

In addition, self-harm is more common in women who have undergone induced abortion.[33] In England, psychiatric hospital admissions because of suicide attempts are **three times** more likely for women after induced abortion, but not before.[34]

The OGS Review concluded that regardless of whether there is a causal link, the observation of the association "suggests careful screening and follow-up for depression and anticipatory guidance/precautions for women who choose elective abortion."[35]

iii. Breast Cancer: Loss of Protective Effect of First Full-Term Pregnancy

Since the 1970's, medical literature has shown that there is a "protective effect of a first full term pregnancy" early in one's reproductive life.[36] "Protective effect" means

---

[32] Amy R. Sobie & David C. Reardon, *Detrimental Effects of Adolescent Abortion*, THE POST ABORTION REVIEW Vol. 9(1), Jan.-Mar. 2001, *at* http://www.afterabortion.info/PAR/V9/n1/teens_vs_older.htm (last visited Jul. 29, 2005).

[33] Shadigian Senate Testimony, *supra* note 16 (citing the OGS Review at 74, n. 97 (A. Gilchrist et al., *Termination of pregnancy and psychiatric morbidity*, BR. J. PSYCHIATRY 167, 1995, at 243-248.)).

[34] *Id.* (citing the OGS Review, *supra* note 2, at 74, n. 93 (C. Morgan et al., *Suicides after Pregnancy*, (letter) BMJ, 314, 1997, at 902)).

[35] OGS Review, *supra* note 12, at 76.

[36] Shadigian Senate Testimony, *supra* note 16 (citing M. McMahon et al., *Age at First Birth and Breast Cancer Risk*, BULL. WORLD HEALTH ORGAN., 43, 1970, at 209-221 (as cited in OGS Review, *supra* note 12, at 75 n. 101)); *See also* Chie W. et al., *Age at Any Full-Term Pregnancy and*

(Continued on following page)

that when a pregnancy is brought to term, a woman's risk of breast cancer is reduced as compared to women who have not given birth. When a woman undergoes an induced abortion, she is losing this protective effect and this decision can almost **double her lifetime risk of breast cancer**.[37] The OGS Review thus concluded that "[i]t is clear that a decision to abort and delay pregnancy culminates in a loss of protection with the net effect being an increased risk."[38]

The OGS Review further concluded that women should be given informed consent about the increased risk of breast cancer related to the "undisputed protective effect of a full-term delivery early in one's reproductive life."[39]

The OGS Review concluded that "a young woman facing an unwanted pregnancy can and should be informed of the loss of that protection that would derive from a decision to terminate her pregnancy and delay having a baby."[40] The authors demonstrated that a decision

---

Breast Cancer Risk, 151 Am J. Epidemiology 715 (2000) (cited in the OGS Review, *supra* note 12, at 75 n. 98).

[37] OGS Review, *supra* note 12, at 76.

[38] *Id.*

[39] *Id.* at 75. Note that the "loss of protective effect of first full-term pregnancy" risk factor is separate and distinct from studies that assess whether induced abortion is an "independent risk factor" for breast cancer. "Loss of protective effect" compares the increased risk of women who have undergone abortion to women who have given birth. By contrast, the "independent risk factor" compares women who have undergone abortion with women who have not been pregnant at all. This brief focuses on the risk of breast cancer due to "loss of protective effect" that results when a woman aborts her first pregnancy because that significant increased risk is "undisputed." *Id.*

[40] *Id.*

of an 18 year old pregnant woman to terminate her pregnancy "can almost double her 5-year and lifetime risk of breast neoplasia at age 50."[41]

The review article stated that "the 'loss of protection' effect is most pronounced in women under 20 years of age who elect to undergo abortion rather than continue their pregnancy."[42] The OGS Review authors thus concluded "that clinicians are obliged to inform pregnant women that a decision to abort her first pregnancy may almost double her lifetime risk of breast cancer through loss of the protective effect of a completed first full-term pregnancy earlier in life."[43]

CONCLUSION

The lower courts' rulings requiring a health exception to an Act that bans the medically dangerous partial-birth abortion procedure is akin to requiring a health exception to an Act that bans the use of crack cocaine. Not only is the banned practice not necessary to preserve anyone's health, it is affirmatively dangerous enough that a legislative body is within its constitutional authority to entirely prohibit the matter as a danger to public health.

For the foregoing reasons, *Amici Curiae,* Professor John M. Thorp, Jr., M.D., and Matercare International

---

[41] *Id.*

[42] *Id.* at 76.

[43] *Id.*

respectfully request this Honorable Court to reverse the judgment of the Court of Appeals.

Respectfully submitted,

JAMES L. HIRSEN
Adjunct Professor of Law
TRINITY LAW SCHOOL
505 S. Villa Real Dr., Ste. 208
Anaheim Hills, CA 92807
Telephone: (714) 283-8880

NIKOLAS T. NIKAS
DORINDA C. BORDLEE
Counsel of Record
BIOETHICS DEFENSE FUND
6811 E. Voltaire Ave.
Scottsdale, AZ 85254
Telephone: (480) 483-3597

Counsel for Amici Curiae

May 22, 2006

- APPENDIX -

The following is the official abstract of the OGS Review. A .pdf version of the entire article is posted on for the Court's review at the following internet address, with the permission of John M. Thorp, Jr., MD:

www.BDFund.org/OGSReview.pdf

Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence

Obstetrical & Gynecological Survey. 58(1): 67-79, January 2003.

Thorp, John M. Jr., MD; Hartmann, Katherine E. MD, PhD; Shadigian, Elizabeth MD

Abstract:

Induced abortion is a prevalent response to an unintended pregnancy. The long-term health consequences are poorly investigated and conclusions must be drawn from observational studies. Using strict inclusion criteria (study population >100 subjects, follow up >60 days) we reviewed an array of conditions in women's health. Induced abortion was not associated with changes in the prevalence of subsequent subfertility, spontaneous abortion, or ectopic pregnancy. Previous abortion was a risk factor for placenta previa. Moreover, induced abortion increased the risks for both a subsequent preterm delivery and mood disorders substantial enough to provoke attempts of self-harm. Preterm delivery and depression are important conditions in women's health and avoidance of induced abortion has potential as a strategy to reduce their prevalence. Only review articles including the single published meta-analysis exploring linkages between abortion and breast cancer were relied upon to draw conclusions. Reviewers

were mixed on whether subsequent breast neoplasia can be linked to induced abortion, although the sole meta-analysis found a summary odds ratio of 1.2. Whatever the effect of induced abortion on breast cancer risk, a young woman with an unintended pregnancy clearly sacrifices the protective effect of a term delivery should she decide to abort and delay childbearing. That increase in risk can be quantified using the Gail Model. Thus, we conclude that informed consent before induced abortion should include information about the subsequent risk of preterm delivery and depression. Although it remains uncertain whether elective abortion increases subsequent breast cancer, it is clear that a decision to abort and delay pregnancy culminates in a loss of protection with the net effect being an increased risk.

Copyright © 2002
By Lippincott Williams & Wilkins, Inc.